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Title: REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION

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## REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION

If you have a specific medical condition that precludes the COVID-19 vaccination requirement and you seek a medical exemption from Los Alamos National Laboratory's COVID-19 vaccination requirement, please consult with your physician and provide the following information. Once fully complete email the completed form and any supporting documentation to [spasqualoni@lanl.gov](mailto:spasqualoni@lanl.gov).

**Please print the following information:**

Name: \_\_\_\_\_ Z number: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Physician Phone No.: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Dear Physician:

Los Alamos National Laboratory requires COVID-19 vaccinations for all employees. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications (<https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html>).

The above person should not be immunized for COVID-19 for the following reasons (Please check all that apply):

- ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine
- ☐ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (Vaccine Ingredients: <https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C>)

Which ingredient caused an allergic reaction? \_\_\_\_\_

What was the reaction? \_\_\_\_\_

Which brand of the COVID-19 vaccine is contraindicated and why? \_\_\_\_\_

How long will the medical contraindication last? \_\_\_\_\_

- ☐ Other Medical Reason – Please provide this information in a separate narrative that describes the other medical reason justifying an exemption in detail.

✓ Diagnosis and date condition began: \_\_\_\_\_

✓ Reason exemption is requested for this diagnosis (provide literature citations where available): \_\_\_\_\_

✓ Anticipated duration of contraindication: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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- ☐ Exemption request approved
- ☐ Extension approved—follow up on date: \_\_\_\_\_
- ☐ Extension approved—start vaccine series by date: \_\_\_\_\_
- ☐ Exemption request not approved

*Please note there is no appeals process available for the determination made by the LANL Medical Director.*

**Medical Director Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_